

FAMILY PRACTICE CODING ALERT

The practical adviser for ethically optimizing coding, payment, and efficiency in family practices

2010, Vol. 12, No. 4 (Pages 25-32)

What's Inside

Clip and Save

Use This J Code List to Prevent Supply Headaches 27
▶ Scan claims for any injectable anti-nausea meds, too

News You Can Use

Avoid Denials With This Lowdown on Newborn CCI Bundles . . . 27
▶ These edits took effect April 1, so start observing them yesterday.

New or Established? Answer Wrong and It Could Cost You 28
▶ Remember, what used to be a consultation is now likely a 99201-99215 service.

You Be the Coder 29
• Outpatient Service or Observation?

Reader Questions

Make Sure Your EHR Passes PQRI Muster 30

Get Specific to Make X-Ray Claims Sail 30

Remember Modifier When FP Only Interprets Ultrasound. 31

Separate Dx Keys This E/M-Injection Combo 31

3 Situations Boost Your Migraine Treatment Smarts

▶ **Acute episodes, check-ups are both routine for these patients.**

When migraine headache coding comes up, ICD-9 codes typically dominate the conversation.

But what about the procedure codes those complicated migraine diagnoses are attached to? There are several common situations in which a migraine patient might report to the FP. Check out the top three migraine treatment scenarios, along with expert coding advice on each situation.

Situation 1: Separate E/M and Acute Migraine Tx

One of your FP's patients might report to the practice with symptoms, and then end up requiring treatment for an acute migraine headache. Consider this example from **Mari Wink RHIT, CPC, ACS-EM**, an independent coding consultant in New York.

Example: An established patient reports to the FP with complaints of recurring headaches. The patient's past medical history indicates that the FP has prescribed several pain medications to combat the headaches, with no success, during previous E/Ms. The patient has, as the FP instructed her during their last encounter, kept a "headache diary" for three months.

During a level-three E/M service, the FP diagnoses "migraine headache w/o aura, HTN." The physician then injects 10 mg of Imitrex via subcutaneous injection, writes a prescription, and sends the patient home.

On the claim, you'd report the following:

- 96372 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular*) for the injection
- J3030 (*Injection, sumatriptan succinate, 6 mg [code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered]*) x 2 for the Imitrex supply
- 99213 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...*) for the E/M
- modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 99213 to show that the E/M and injection were separate services

(continued on next page)

• 346.10 (*Migraine without aura; without mention of intractable migraine without mention of status migrainosus*) appended to 99213, 96372 and J3030 to represent the patient's migraine

• 401.X (*Essential hypertension*) appended to 99213 as a secondary diagnosis, reflecting a comorbid condition.

(Note: For more information on the medications the FP will use during migraine treatments, and how you can code for them, see "Use This J Code List to Prevent Supply Headaches.")

Documentation alert: In order to prove medical necessity for the Imitrex injection, the notes should include proof that the FP did try alternate methods of treatment before performing the injection. "It should read something like: 'Patient has not responded well to past medication regimes as documented in previous office visits. Today we are going to inject Imitrex,'" recommends Wink.

Situation 2: Capture Care Plan Work in E/M Choice

After your FP diagnoses a patient with migraines, he often begins a plan of care to help the patient better manage her migraines, confirms **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of Denver's MJH Consulting.

According to Hammer, a patient with a migraine diagnosis might report to the FP for:

- diagnosis management of his migraine

• medication management, including writing new or refilling current prescriptions

• evaluation of efficacy of plan of care including abortive management

• assessment of side effects associated with current treatment plan.

When the physician or nonphysician practitioner (NPP) treats migraine patients for any of the above reasons, code the appropriate E/M code or other CPT code[s].

Example: An established patient with a plan of care in place for her classic migraines reports to the FP for medication management. An NPP asks the patient how she is reacting to the medication, and if there have been any side effects. The patient reports that everything is "going fine so far." Notes indicate a level-two E/M service.

For this condition-management E/M, you'd report 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ...*) with 346.00 (*Migraine with aura; without mention of intractable migraine without mention of status migrainosus*) appended to represent the patient's migraines.

Situation 3: ID Injections in Migraine Intervention

A patient with a plan of care in place might also have an acute migraine that requires FP intervention. When

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Use This J Code List to Prevent Supply Headaches

► Scan claims for any injectable anti-nausea meds, too.

If a patient reports to the FP for an injectable migraine treatment, the supply code choices can send a coder's head spinning. We asked **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of Denver's MJH Consulting, if there was a list of injectable drugs that migraine patients receive.

There is no complete list of injectable migraine medications anywhere, but "these are the more common injectable medications potentially administered in a physician office," Hammer offered:

- Toradol: J1885 (*Injection, ketorolac tromethamine, per 15 mg*)
- Triptans, (or Imitrex, Sumatriptan): J3030 (*Injection, sumatriptan succinate, 6 mg [code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered]*)
- DHE-45 (or Migranal): J1110 (*Injection, dihydroergotamine mesylate, per 1 mg*)
- Butorphanol, (or Stadol): J0595 (*Injection, butorphanol tartrate, 1 mg*)
- Demerol: J2175 (*Injection, meperidine HCL, per 100 mg*)
- Botulinum toxins: J0585 (*Injection, onabotulinumtoxinA, 1 unit*) through J0587 (*Injection, rimabotulinu toxinB, 100 units*).

Additionally: The FP might also inject the following drugs "for nausea associated with migraines," says Hammer:

- Compazine: J0780 (*Injection, prochlorperazine, up to 10 mg*)
- Phenergan J2550 (*Injection, promethazine HCL, up to 50 mg*).

Caveat: You likely won't come into contact with all of these supply codes. The amount and variety of migraine drugs in the primary care setting will "depend upon the quantity of active migraine patients" your FP treats, Hammer reminds. □

this occurs, you'll report an E/M or injection - or both, depending on the situation. Consider this example from Hammer:

Example: An established female patient with a history of menstrual migraines presents having an acute menstrual migraine with new onset of neurological symptoms. After attempting to stop the migraine with oral pain medication, the FP injects the patient with 6 mg of Imitrex and 1 unit of Compazine. Notes indicate a level-four E/M service.

On the claim, report the following:

- 96372 x 2 for the injections
- J3030 for the Imitrex supply
- J0780 (*Injection, prochlorperazine, up to 10 mg*) for the Compazine supply
- 99214 (... *a detailed history; a detailed examination; medical decision making of moderate complexity* ...) for the E/M
- modifier 25 appended to 99214 to show that the E/M and injections were separate services
- 346.40 (*Menstrual migraine; without mention of intractable migraine without mention of status migrainosus*) appended to 96372, J3030, J0780, and 99214 to represent the patient's condition. □

News You Can Use

Avoid Denials With This Lowdown on Newborn CCI Bundles

► These edits took effect April 1, so start observing them yesterday.

The latest version of the Correct Coding Initiative (CCI) has an edit that FP coders should note - especially if the practice treats newborn patients.

Get to know the new CCI 16.1 edit and get ready to observe it with this expert breakdown.

Check Column 1 on These Hospital E/Ms

According to CCI 16.1, these codes are in column 1 of the mutually exclusive edits:

- 99231 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; medical*

(continued on next page)

decision making that is straightforward or of low complexity ...)

- 99232 (... an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity ...)
- 99233 (... a detailed interval history; a detailed examination; medical decision making of high complexity ...).

Column 2 of these edits includes these codes:

- 99460 (Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant)
- 99461 (Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center)
- 99462 (Subsequent hospital care, per day, for evaluation and management of normal newborn).

Translation: An FP may not report both normal newborn care and subsequent hospital care for a newborn on the same date of service. If the FP performs normal newborn services (99460-99462) on the same date that the newborn later becomes ill and receives subsequent hospital care (99231-99233), you should only report a code from the 99231-99233 code set, explains **Kent Moore**, manager of health care financing and delivery systems for the American Academy of Family Physicians (AAFP) in Leawood, Kan.

The services are mutually exclusive because the newborn care codes (99460-99463) are for “normal” newborns (i.e., newborns without medical problems); whereas the subsequent hospital care codes (99231-99233) are for problem-oriented services, Moore says.

Since both sets of services are designated as “per day,” coders must choose between them for a given patient on a given date. “Consistent with the mutually exclusive nature of these services, CCI does not permit a modifier to override the edits,” Moore continues.

Bottom line: Never report 99460-99262 and 99231-99233 for the same patient on the same date of service. □

New or Established? Answer Wrong and It Could Cost You

► **Remember, what used to be a consultation is now likely a 99201-99215 service.**

Dr. FP provides a new patient with a standard office-visit E/M. You use an established patient E/M to code the encounter. No big deal, right?

Wrong: Not only is the coding incorrect, but this mistake will cost your practice deserved reimbursement. Further, Medicare’s deletion of consultation codes means that coders will have to answer the new vs. established question more often than before.

For Medicare payers, and payers that follow their lead, coders will now have to “select the correct code, new or established, to bill for what used to be consults and did not have a new versus established component concept,” relays **Quinten A. Buechner, M.S., M.Div., AAPC:CPC, BMSC:ACS-FP/GI/PEDS, ACMCS:PCS, PHIA:CCP, PAHCS:CMSCS**, president of ProActive Consultants, LLC in Cumberland, Wis.

Don’t get Dr. FP steamed; nail the patient’s status every time by following this expert advice on new and established patients.

Leave Money on the Table if You Ignore New Patient E/Ms

For FP practices, the main difference between new and established patient codes is the payment rate. Consider this comparison of average national payouts for new and established level-two E/M codes, respectively:

- 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded

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problem focused history; an expanded problem focused examination; straightforward medical decision making ...) pays about \$67 per encounter (1.87 transitioned nonfacility relative value units [RVUs] multiplied by the temporary 2010 Medicare conversion rate of 36.0846)

• 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ...*) pays about \$39 per encounter (1.08 transitioned nonfacility relative value units [RVUs] multiplied by the temporary 2010 Medicare conversion rate of 36.0846).

That's almost \$30 lost if you mistakenly report 99212 instead of 99202. The main difference between a new and established patient visit, service-wise, can be minimal: it often includes simple tasks such as "setting up a new chart and quizzing the patient a little closer to get familiar with him," explains Buechner.

(Note: While there are some exceptions, non-Medicare payers generally adhere to Medicare's new/established patient rules. If you are unsure about the status rules for a private payer, check out your contract before filing a claim.)

Ask 3-Year Question 1st

If your patient has had a face-to-face service with the FP (or another physician with the same specialty credentials in your group) within the last three years, then the patient is established, confirms **Kami Culb**, office coordinator at Frederick Memorial Hospital Immediate Care in Frederick, Md.

So let's say a patient reports to Dr. FP for a level-three E/M service on April 20, 2010. The patient's record indicates that she received a face-to-face E/M service from Dr. FP on Dec. 14, 2008. This is an established patient, so you should report 99213 (*... an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...*).

Face Time a Must for Established Patients

What does a coder do when the patient has received treatment from Dr. FP within the last three years, but the physician did not actually lay eyes on the patient? This is a different coding situation, confirms **Shelby Davidson, CPC, CMSCS**, coding educator at OHMFS in Ohio.

Do this: "Interpret the phrase 'new patient' to mean a patient who has not received any professional services - in other words, an E/M service or other face-to-face service - from the physician or physician group practice within the previous three years," she recommends.

This means that you might be able to report a patient as new if Dr. FP provided services for the patient less than three years ago - provided it was not a face-to-face-service.

Example: A patient reports to Dr. FP for an E/M service. The patient's record indicates that Dr. FP read the results of the patient's cardiac screening on May 5, 2009. There was no record of a face-to-face service. You should choose a new patient E/M code for this encounter (99201-99205).

Explanation: When the physician "reads an x-ray, EKG, etc., in the absence of an E/M service or other face-to-face service with the patient, it does not affect the new patient designation," explains Davidson.

Check Specialty When Deciding Status

Coders that work in multispecialty practices will have to pay attention to one more new/established patient status rule, confirms **Cathy Satkus, CPC**, coder for Harvard Family Physicians in Tulsa, Okla.

Example: You are a coder for Dr. FP, who is part of a multispecialty practice that includes urologists, gastroenterologists, and otolaryngologists. A patient reports to Dr. FP for an E/M service on March 15, 2010. The patient's medical record indicates that he received a covered screening colonoscopy from Dr. G, the practice's gastroenterologist, a year ago but has not otherwise seen Dr. FP or any other family physicians within the practice in the past three years.

You would code this as "a new patient, since the specialty is different," Satkus says. □

You Be the Coder

Outpatient Service or Observation?

Question: *The FP meets a 46-year-old established female patient at the local hospital at 2 p.m. Wednesday; she has suffered syncope secondary to severe dehydration due to her influenza. The physician documents a comprehensive history, comprehensive exam, and medical decision making of moderate complexity. The physician and staff work to rehydrate the patient and provide her with anti-nausea medicine; she responds positively to both treatments. Blood work reveals she is adequately hydrated and her blood pressure is stable, so the patient is sent home at 10:23 p.m. Wednesday. Is this an established outpatient visit or an observation E/M service?*

California Subscriber

Answer: See page 31. □

READER QUESTIONS

Make Sure Your EHR Passes PQRI Muster

Question: *We have been participating in the physician quality reporting initiative (PQRI), and I heard that you could report a measure if your practice is implementing electronic health records (EHR). We started making the transition from paper to digital record-keeping in January 2010; is there an EHR measure in the PQRI pantheon?*

Missouri Subscriber

Answer: There is a measure that you can report for using EHR: Measure 124 (*Health Information Technology: Adoption/Use of Electronic Health Records [EHR]*). According to CMS, providers satisfy the measure when they document “whether provider has adopted and is using health information technology.”

Coding: There are no diagnosis coding requirements for this measure. So if a new patient reports to the FP for a level-two E/M service and the encounter is documented via EHR, you’ll report the following for the encounter:

- 99202 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making ...*) for the E/M
 - either G8447 (*Patient encounter was documented using a CCHIT certified EHR*) or G8448 (*Patient encounter was documented using a qualified [non-CCHIT certified] EHR*) to indicate you are reporting PQRI measure 124.

Red alert: In order to report PQRI Measure 124, you must be using an EHR system that is CCHIT certified or, at minimum, “qualified.” Check out these quick definitions of certified and qualified systems:

CCHIT certified: Confirm your EHR’s specs if you are unsure, but on most Certification Commission for Healthcare Information Technology (CCHIT) certified EHRs, users can:

- manage a medication list
- manage a problem list
- manually enter or electronically receive, store and display laboratory results as discreet searchable data elements
- meet basic privacy and security elements.

Qualified EHR: In Medicare’s eyes, a qualified EHR must satisfy the above requirements and be on its way to certification – and fast. “The [qualified] EHR must be

CCHIT certified on or before August 1, 2011, or another CCHIT certified product must be in use for compliance after August 1, 2011,” CMS states.

To find CCHIT certified EHRs, you can visit the CCHIT web site at: <http://www.cchit.org/products>.

For more information on PQRI reporting check out: http://www.cms.gov/PQRI/Downloads/2010_PQRI_MeasuresList_111309.pdf.

Get Specific to Make X-Ray Claims Sail

Question: *A 38-year-old established patient reports to the FP with complaints of wheezing, coughing and trouble catching her breath. After the non-physician practitioner (NPP) performs a problem focused history, the FP performs an expanded problem focused exam and discovers focal rhonchi. The FP orders a two-view chest x-ray to check for upper respiratory infection (URI). The chest x-ray results reveal acute URI, and the rhonchi clears up upon reevaluation. We own the x-ray equipment, and the overall notes indicate a level-three-E/M. How should I code this scenario?*

Kansas Subscriber

Answer: You’ll submit a pair of CPT codes, a pair of ICD-9 codes, and a modifier to make this coding correct. On the claim, report the following:

- 71020 (*Radiologic examination, chest, 2 views, frontal and lateral;*) for the x-ray
- 99213 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...*) for the E/M
 - modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 99213 to show that the E/M and x-ray were separate services
 - 465.9 (*Acute upper respiratory infections of multiple or unspecified sites; unspecified site*) appended to 71020 and 99213 to represent the patient’s URI
 - 786.7 (*Symptoms involving respiratory system and other chest symptoms; abnormal chest sounds*) appended to 71020 and 99213 as a secondary diagnosis to represent the patient’s focal rhonchi.

Secondary Dx decoded: Even though the focal rhonchi cleared up on reexamination, you should still include 786.7 on the claim. It will help paint a more lucid

portrait of the patient's condition, and can only strengthen your medical necessity case for the chest-x-ray.

Remember Modifier When FP Only Interprets Ultrasound

Question: *The FP meets a 28-year-old established patient who is 24 weeks pregnant at a local hospital; she says she has been "throwing up almost constantly" for four days. During a level-four E/M service, the FP discovers that the patient is also experiencing abdominal cramping, but no diarrhea or fever. He orders a limited ultrasound to check on the fetus. The fetus shows no signs of complications due to the mother's condition, so the FP discharges the patient with prescriptions, and instructions to report to the office if her vomiting has not abated within four days. Final diagnosis was "hyperemesis grav. w/metabol. dist. No dehydration." How should I code this scenario? Can we report for the ultrasound, since it occurred in the hospital?*

Montana Subscriber

Answer: The E/M and ultrasound are separately codeable; however, since the FP used the hospital's equipment for the ultrasound, you'll need some modifier help to get the claim ready for filing.

On the claim, report the following:

- 76815 (*Ultrasound, pregnant uterus, real time with image documentation, limited [e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume], 1 or more fetuses*) for the ultrasound
 - Modifier 26 (*Professional component*) appended to 76815 to show that you are only coding for the FP's interpretation and report of the ultrasound (the facility will bill for the use of the ultrasound equipment)
 - 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity ...*) for the E/M
 - Modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 99214 to show that the E/M and US were separate services
 - 643.13 (*Hyperemesis gravidarum with metabolic disturbance; antepartum condition or complication*) appended to 76815 and 99214 to represent the patient's hyperemesis and current episode of care.

Separate Dx Keys This E/M-Injection Combo

Question: *A 75-year-old established Medicare patient with a plan of care in place for her pneumococcal meningitis reports to the FP for a scheduled Rocephin injection. A qualified non-physician practitioner (NPP) injects the patient with 750 mg of Rocephin. After the injection, the patient says "My shoulder really hurts." During a problem focused history and exam, the NPP diagnoses adhesive tendinitis in the patient's right shoulder, and recommends acetaminophen and rest for the injury. Can I report the E/M and the injection?*

Wisconsin Subscriber

(continued on next page)

You Be the Coder

(Question on page 29)

Outpatient Service or Observation?

Answer: It depends on whether or not the patient was designated as "observation status." If so, report the following:

- 99235 (*Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity ...*) for the observation service
 - 276.51 (*Disorders of fluid, electrolyte, and acid-base balance; volume depletion; dehydration*) appended to 99235 to represent the patient's dehydration
 - 780.2 (*Syncope and collapse*) appended to 99235 represent the patient's syncope
 - 487.8 (*Influenza; with other manifestations*) to reflect the patient's influenza as a causal factor leading to other manifestations (dehydration and syncope).

If the patient was not designated as "observation status," then you are left to code the encounter with an established outpatient visit code. Based on the level of history, exam, and medical decision making involved and given the patient's status as "established," 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity ...*) might be appropriate in this instance. □

Answer: You can code for the injection and the E/M in this instance. On the claim, report the following:

- 96372 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular*) for the injection
- J0696 (*Injection, ceftriaxone sodium, per 250 mg*) x3 for the Rocephin supply
- 320.1 (*Bacterial meningitis; pneumococcal meningitis*) appended to 96372 and J0696 to represent the patient's condition
- 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ...*) for the E/M
- Modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 99212 to show that the E/M and the injection were separate services
- 726.0 (*Adhesive capsulitis of shoulder*) appended to 99212 to represent the patient's shoulder injury.

Remember: The reason that you can code the injection and E/M is that the services were for significant and separately identifiable, which is further supported by the fact that they involved distinct patient issues (meningitis, sore shoulder). Make sure your diagnosis codes line up to the appropriate codes, or you could be facing a denial.

Also, you should not code this encounter as incident-to the physician, as the NPP treated a new problem. In order to report an incident-to service, the NPP must be following a plan of care for a previously diagnosed condition for the service.

— *Information for and answers to You Be the Coder and Reader Questions reviewed by Kent Moore, manager of health care financing and delivery systems for the American Academy of Family Physicians in Leawood, Kan.* □

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